February 3, 2009

Health Workforce Pilot Projects Program
Interview with
Supervisor-Preceptor
171—07-100
Concord, California

Interview Elements	Comments/Notes					
	BRN	**MBC**	**Assoc. of Reproductive Health Professionals**	**American College of OB-GYN, District IX**	**Technical Consultants**	**OSHPD-HWPP**
Overview of Present Position: 1. What are your current responsibilities with the Clinic? 2. Please share some of your experiences with us in providing abortion care, miscarriage management, post discharge care? 3. What inspired you to participate in the pilot program?	T-11 Trainer of 4 nurse practitioners. Have taught abortion procedures to MDs in the past.	No report received.	T - 11 This clinician is clearly an excellent clinical trainer and supervising physician. He has taken on this responsibility enthusiastically and is clearly providing the trainees with appropriate supervision and mentoring.	T - 11	T - 11 Interview with T-11 who described experiences related to precepting and evaluating each trainee.	T-11 T-11 is the preceptor for this site. T-11 has been a physician for approximately twenty-six years. He specializes in the following areas: HPV, abortions services, obstetrics-gynecology. He is a member of the Federation of Medical Directors and enjoys teaching, consulting and precepting.
Pilot Project Role: 1. Describe your understanding of the supervisor/preceptor role. 2. Do you feel comfortable/competent in your new role as supervisor/preceptor? 3. How frequently are you in contact with the trainees assigned to you? 4. Are you generally scheduled to work the same day and shift as the trainee? 5. Is there a back-up preceptor system available in your facility? 6. Who assigns the trainees to patients? Describe method of assignment. 7. Are there occasions where more than one trainee is assigned to a patient? If so, discuss. 8. Have there been instances when patients are reassigned/changed and given to a non-trainee practitioner? If so, discuss.	Have built-up the comfort level of the trainees which makes them successful. They know their limitations. Spoke about the need for the NPs to keep up their skills in doing the procedures. The supervisor/preceptor selects the patients for the trainees.			Patient's health and safety should be the primary concern. Having an OB/GYN supervisor off-site while midlevel practitioners are performing these procedures may not be in the patient's best interest. Procedures done with an off- site physician need to be monitored very closely and separately from the other procedures done with a physician on-site.	Preceptor is now training on a one-to-one the 4th trainee. The preceptor chooses appropriate clients for the trainee at their skill level using age guidelines and parity. Each case is discussed with the APC before and after the procedure. Clinical case discussions are also done with all trainees about interesting cases that present learning opportunities for APC's as well as other physicians. T-11 feels that the model of trainee education should be adapted to the clinical training site and type of facility as each will have specific guidelines relative to that facility. It is important to have the flexibility to adapt the educational model as needed to the trainee and the facility in which the APC practices.	He has trained the 4 APCs located at this site. He is with the trainees during their didactic and clinical training phases. Now that they are in the practice phase, he is available to them and will evaluate their performance logs. While he is the preceptor for this project, other physicians are also able to observe the work of the APC as they perform procedures.

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Trainee Evaluation: 1. What areas of strength have you identified in the Trainee's performance? 2. Have you identified any performance weakness? If so, what remedial activities were undertaken to improve the trainee's performance? 3. Are the trainees able to obtain signatures on the patient consent form satisfactorily? N/A	Continued to work with a trainee who had a "gap" in doing abortion procedures and when he thought she had lost confidence in doing the procedure. The trainee was successful		He answered questions about how he evaluates trainees and when he would limit their advancement to the next level of independence appropriately. I have full confidence in this trainer's competence as a clinician, trainer and supervisor.	Physicians in all types of practice are monitored for continuing procedural competence. The midlevel practitioners need to have similar monitoring.		He observes the trainees competency and their comfort level as they move through the types and number of procedures being performed. He checks their ability to look at the ultrasound results for visualization, determines how they complete their procedures. He prefers that the APC training be on a continuous basis rather than having a 'gap' in time (e.g. month). However, he feels that the training competency is knowing that gaps in scheduling procedures occur. Thus, they build confidence during their training period. The trainees keep their logs of procedures performed. The logs/cases are reviewed and discussed. These trainees know their limitations. It is when a trainee does not know their limitations that scare you. If at any point a trainee does not appear to grasp the training, he would not advance the trainee to the next levels. At that point, he would indicate that perhaps this is not the procedure or field that the trainee should be in. He attempts build their confidence in the procedures to be performed.

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Clinicals: **1.** Were there any unusual occurrences or incidents observed/reported with the abortion care procedures/care provided by the trainee? Discuss. 2. Discuss the referral policy/procedures or patients presenting themselves to the clinic but are in need of a transfer to a GAC or other healthcare facility\setting? Who makes the referral? 3. Were any of the trainees assigned to patients (initially or otherwise) who required a transfer? 4. Do you feel the preparation for the employment/utilization phase was satisfactory or is there need for changes? 5. Are the trainees involved in any post care/follow-up care of patients who were serviced and discharge from your clinic?				At this site I visited, there may have been a shortage of procedures for all the training, and maintenance of competence for all providers of surgical uterine evacuations. It would be disappointing if physicians in training who are motivated and interested in acquiring this surgical skill were not trained as a result of midlevel practitioner training.		Trainees have not experienced any unusual occurrences. They have had experience/exposure to 'the feel' of different uterine positions, determining methodology for equipment insertions, ultrasound usage, abortion products.
Reporting Procedures/Shared Information: 1. Describe the method of reporting and/or how information is shared regarding pilot project observations. 2. Have you had a chance to review the patient questionnaires? If so, what were your findings? 3. What other records do you manage\maintain? 4. What are your expectations regarding the outcome of this project? 5. Are there any other comments, or information you would like to share with us?						Cases are reviewed and discussed with the trainees. The trainees are in the practice stage and are performing at the expected competency levels for the project.